WELCOME TO OUR OFFICE
PLEASE PRINT

Date _____

Patient's Name (Mr. Mrs. Miss Ms. Dr. Sr. Rev.)_____ _____ _____
LAST FIRST M.I.

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Date of Birth _____ Age _____ Social Security No. _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Separated

Race: ☐ Refused Answer ☐ African American ☐ White ☐ Asian ☐ Other

Ethnicity: ☐ Refused Answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino Language:_____

Spouse's Name _____ Parent (if minor) _____

Emergency Contact_____ Telephone_____

Patient's Family Physician_____ Allergies _____

Physician's Address_____

Referred by _____

Name of Employer _____ Business Phone_____

Patient's Occupation _____

Address _____City_____ State _____ Zip _____

Pharmacy _____ Pharmacy Phone_____

Pharmacy ID. # _____

Pharmacy Address _____ Mail Order Pharmacy_____

_____ _____

_____ _____

Please Complete Insurance Information — See Reverse Side

MEDICARE

I request that payment of authorized medicare benefits be made either to me or on my behalf to Ophthalmology Associates of Staten Island for any services furnished me by the physician/physicians in the above mentioned office.

I Authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for dated services.

Patient's Signature _____ Date _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____Phone _____

Address_____

Policy Holder Name (Mr. Mrs. Miss Ms. Dr. Sr. Rev.) _____

Date of Birth _____ Social Security No. _____

Employer_____

Policy No. _____Group No. _____ID No. _____

SECONDARY INSURANCE COMPANY _____ Phone _____

Address _____

Policy Holder Name _____ Date of Birth _____

Employer _____

Policy No. _____ Group No. _____ ID No. _____

OTHER INSURANCE _____ Phone _____

Address _____

Policy Holder Name _____

• • • PLEASE NOTE • • • SIGNATURES REQUIRED

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. Signature_____ Date_____

I authorize the release of any medical information necessary to process this claim.

Patient's Signature _____ Date _____

I authorize the release of payment for medical benefits to my physician.

Patient's Signature _____ Date _____

FOR ALL NO FAULT AND WORKERS COMPENSATION CASES

Insurance or Employer Name & Address _____

Date of Accident _____ _____ _____

Phone _____ Claim No. _____Policy No. _____

Insured's or Policy Owner's Name _____Lawyer's Name _____